The Three R’s
Risk Leveling Programs in the Affordable Care Act

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The Three R's

"Risk leveling" programs required by the Affordable Care Act (ACA) to help protect insurers in the individual and small group markets against risk selection and market uncertainty, and ensure Exchange and market viability.

Reinsurance *(temporary)*

Protects insurers offering individual coverage from the risk of high cost claims and allows for lower premium levels.

Risk Adjustment *(permanent)*

For individual and small group insurers, assesses charges to insurers with enrollment of less-than-average risk and "transfers" those dollars to insurers with enrollment of higher-than-average risk.

Risk Corridors *(temporary)*

Limits the extent of issuer gains or losses inside the Exchange. Insurers with costs less than projected remit a percentage of savings to HHS; insurers with costs more than projected receive a payment from HHS.

Administering The Three R's

- Reinsurance
  - A state that operates an Exchange may, but is not required to, establish a reinsurance program
  - If a state does not establish an Exchange, it can still operate its own reinsurance program
  - If a state does not establish its own reinsurance program, HHS will perform the reinsurance functions for the state
- Risk Adjustment
  - A state that elects to operate an Exchange is eligible to establish a risk adjustment program, but is not required to do so
  - HHS will perform the risk adjustment function for a state that does not elect to operate an Exchange
- Risk Corridors
  - HHS will administer the risk corridor program

Why The 3R's Matter

- Risk-leveling programs are critical to a viable health benefit market post 2014
- Adverse selection must be minimized to ensure adequate choice and affordability
  - Adverse selection occurs when individuals at greater risk of high health spending are more likely to purchase coverage than low-risk individuals
  - Higher premiums result which lead to more low-risk individuals opting out of coverage which lead to even higher premiums
- Insurers will not be able to price Exchange products accurately if the 3 R's are not clearly understood, modeled, and communicated

Increased Insurer Risk Under ACA

- Guaranteed issue means insurers must accept all applicants regardless of health status
- Individual mandate does not have adequate penalties to ensure that healthy individuals will comply
- Insurers will be prohibited from excluding pre-existing conditions or varying premiums based on health status
- Substantial influx of previously uninsured individuals will make it difficult to price plans accurately
- High risk individuals will add cost to the market that were previously managed separately
- Risk adjustment is untried in the individual and small group markets

Risk Adjustment

- Individual Risk Score –
  - A relative measure of predicted health care costs for a particular enrollee that is the result of a risk adjustment model
- Risk Adjustment Model –
  - An actuarial tool used to predict health care costs based on the relative actuarial risk of enrollees in risk adjustment covered plans
- Calculation of Plan Average Actuarial Risk –
  - The specific procedures used to determine plan average actuarial risk from individual risk scores for a risk adjustment covered plan
- Risk Adjustment Covered Plan –
  - Any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, Medicare or Medicaid plans, and those offering solely excepted benefits

Risk Adjustment

- Calculation of Payments and Charges –
  - The methodology applied to plan average actuarial risk to determine risk adjustment payments and charges for a risk adjustment covered plan
- Risk Adjustment Data –
  - All data that are used in a risk adjustment model, the calculation of plan average actuarial risk, or the calculation of payments and charges, or that are used for validation or audit of such data
- Federally Certified Risk Adjustment Methodology –
  - A risk adjustment methodology that either has been developed and promulgated by HHS or has been certified by HHS

Risk Adjustment Timing

- October 2012 – HHS announces federally certified risk adjustment models
- Calendar Year 2014 – Year One for risk adjustment
- March 2015 – Data for 2014 ready for risk adjustment
- June 2015 – Payments and charges determined for calendar year 2014
- July 2015 – Payments due (or received)

All Payer Claims Database (APCD)

- Availability of market data is critical for understanding the impact of risk adjustment on market issuers
- An individual carrier cannot know the financial impact of risk adjustment on their own business without knowing how their average risk score compares to the state average
- Without this knowledge, uncertainty by insurers will likely lead to conservative assumptions and higher premiums
  - Understating premiums could result in large losses to insurers, threatening plan solvency
  - Overstating premiums could result in large gains to insurers or reduced enrollment

Uses of an APCD

- Analyze and prepare simulations in advance of actual risk scoring
- Allow carriers to understand their own risk in relation to the market
- Allow interim risk scoring in 2014 after new populations enter the market
- Moderation of market pricing variations through advance knowledge of average risk scores